Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N023009	A. BUILDING _____ B. WING _____	C 12/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citation represent the findings of Complaint Investigation #KS61996.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: K.A.R.26-41-101(f)(1)(B) The facility identified a census of 37 assisted living residents that resided on two units. Sample size included 4 residents. Based on observation, record review, and interview the facility failed to have a system in place to notify the staff of the code status of the residents. This deficient practice placed this resident in Immediate Jeopardy. Findings included: - Resident #1's face sheet revealed the resident admitted to the facility on 4/23/12 and was a full code (the resident wanted cardiopulmonary resuscitation [CPR]). The Resident Function Capacity Screen dated 8/12/12 identified the resident was independent with activities of daily living. The Negotiated Service Agreement dated	S3026		

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S3026	Continued From page 1 4/23/12 documented the resident received supervised nursing services. Observation of the chart binder on 12/19/12 at 1:30 P.M. revealed on the inside of the front cover staff had placed a green sticker that identified the resident as a full code. The Resident Service Plan last reviewed on 8/11/12, included no information regarding resident's advance directives. The nurse's note dated 11/25/12 and timed 8:00 A.M. revealed the staff brought the resident his/her breakfast tray and the resident would not respond to verbal cues. The staff person called the North unit nurse to come and check the resident. The nurse's note dated 11/25/12 and timed 9:30 A.M. revealed licensed nurse C had received a phone call from direct care staff D on assisted living and had asked him/her to come "check out" a resident. The nurse arrived at the resident's room at 8:30 A.M. the resident laid in bed with his/her face into the pillow with liquid bubbling from his/her mouth. This nurse listened to the resident's heart and the resident had a faint heartbeat, very shallow breathing, and did not respond to verbal sounds. Licensed nurse C listened to the heart again and heard no heart sounds. The nurse also listened to the carotids and no sounds and no pulse on either radial. This nurse called another nurse to come and assess also. The additional nurse did not detect a radial pulse or heart sounds. Licensed nurse C called the nurse manager on duty and that nurse arrived at 8:53 A.M. The facility's investigation revealed on 11/25/12 at	S3026		

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S3026	Continued From page 2 8:20 A.M. that direct care staff D called licensed nurse C to come "check out" resident #1. Licensed nurse C arrived at the room at 8:30 A.M. and found the resident in bed and did not respond to his/her name. Upon auscultation the nurse heard a faint heart sound. Licensed nurse C asked direct care staff D if the resident was a Do Not Resuscitate (DNR). The direct care staff stated he/she did not know so they both looked in the records under Advance Directives and did not see anything in the chart regarding the code status. Licensed nurse C called a family member who requested the staff to transfer the resident to the hospital. Licensed nurse C, after finishing the phone call to the family member, observed the resident did not have any respirations or heart sounds. Neither the nurse nor the direct care staff started cardiopulmonary resuscitation. The licensed nurse called the nurse manager on duty. The staff did not transfer the resident to the hospital as the family requested. The staff did not initiate CPR as planned. Licensed nurse E documented on 11/25/12 and untimed, at approximately 8:45 A.M. he/she was called and told resident #1 had no pulse or respirations. Licensed nurse E arrived at the resident ' s apartment at 8:53 A.M. and found the resident with no carotid, apical, or radial pulse. The investigation further revealed when licensed nurse C picked up the chart after the nurse manager on duty had arrived to the room, he/she saw the resident had a Full Code sticker on the inside of the front cover of the chart binder. Direct care staff D on 12/19/12 at 2:35 P.M. stated resident #1 had been sick and he/she had checked on him/her three times since the	S3026		

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S3026	Continued From page 3	S3026		

beginning of his/her shift. On the third time the resident would not talk to him/her so direct care staff D called the nurse on the north unit and asked him/her to come check the resident, it was not an emergency but the resident was not acting right. When the nurse arrived the nurse took the resident ' s pulse and it was weak and the nurse called a family member and the family member requested for the resident to go to the hospital.

Licensed nurse C on 12/20/12 at 10:00 A.M. stated he/she worked on the skilled unit and had never met resident #1 before. Licensed nurse staff D asked him/her to come look at the resident but did not tell her anything about the resident ' s condition when he/she called. When this nurse arrived to the room direct care staff D told him/her that the resident was sick for the last couple of days. The resident had faint heart sounds. Licensed nurse C called a family member who requested the nurse to send the resident to the hospital. When this nurse looked back at the resident, the resident was not breathing. Licensed nurse C along with direct care staff D, looked under the advance directive section of the chart and did not find anything. Licensed nurse C stated he/she decided not to provide CPR because most of his/her residents were DNRs. He/she also stated direct care staff D did not know if the resident was a DNR or not.

The direct care staff did not report to the nurse what signs and symptoms the resident had and did not communicate the resident's condition was serious.

Direct care staff F 12/19/12 at 8:05 A.M. stated the assisted living staff used the report sheet to note any changes in the residents but it did not list the resident's code status. The only way the

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S3026	Continued From page 4 staff knew the resident's code status was to come to the locked medication room where staff store the charts and look on the inside of the binder. Direct care staff F if a resident quit breathing I would call 911 and the nurse, and start CPR. Licensed nurse G on 12/10/12 at 11:15 A.M. stated that any nurse that received a call from the assisted living units would go over and assess the resident. The nurse would have no way of knowing the resident s code status unless they looked at the clinical record. Licensed nurse H on 12/19/12 at 11:19 A.M. stated when he/she received a call from assisted living he/she would go to the unit and assess the resident. When the nurse went to assisted living there was not a way to tell the code status so I just assumed everyone was a full code. Licensed nurse J on 12/19/12 at 12:30 P.M. stated there was not a way to tell the resident's code status without looking in the record. Administrative licensed nurse I on 12/19/12 at 8:10 A.M. stated the staff should treat all residents as a full code until the staff saw documentation that told them differently. The direct care staff was in charge on the assisted living units and if they needed a nurse they should call the North nurses' station. The facility did not have a current policy for notification of the resident's code status and initiation of CPR. The staff did not follow the facility's policy and procedure for initiating CPR for this resident as planned.	S3026		

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S3026	Continued From page 5 The facility failed to have a system in place and failed to educate the staff regarding code status. A resident who had requested to have CPR initiated was not provided the life sustaining measure and died. The facility's failure to have an effective system to identify advance directives placed this resident in immediate jeopardy. The facility abated the immediate jeopardy when the facility developed a policy for the Initiation of Code Blue which included: staff to call for help, obtain code status and follow directive (red dot on apartment/suite door indicated resident had a DNR in chart. Copy of original DNR in chart), call 911, if code status is not immediately known, initiate CPR, obtain code status and follow directive, call to inform of Code Blue the nurse manager on duty, resident services director, and the director of nursing, a staff member must remain with the resident at all times, contact the resident's physician for further orders, contact the resident's responsible party to inform him/her of the change in condition, continue CPR efforts until the ambulance service arrives or until spontaneous respirations, pulse and blood pressure return. Assisted living residents who have a DNR code status would have a sticker applied to the door of their apartment (hall side). The resident Services director initiated and was responsible for maintaining the program to designated resident code status. Staff would review the code status and red sticker placement at resident service plan meetings quarterly or upon a significant change in health status. The Resident Services Director or designee would check status of red stickers daily for 30 days. The Resident Services Director would forward the	S3026		

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S3026	Continued From page 6 results of these audits to the QA committee for review and action if necessary. Administrator had placed an order with the Human Resource Department to hire and additional weekend nurse. The facility provided education to all assisted living staff, skilled nursing facility nurses, and resident services on the meaning of the placement of the red stickers on the assisted living resident's doors and the new policy for the Initiation of Code Blue. The facility completed these interventions on 12/20/12 at 5:00 P.M. This deficiency remains at a scope and severity of a G.	S3026		